Washington State Health Care Authority

☐ Approved Initial _____
☐ Not Approved Initial _____

EFFECTIVE DATE CHANGE REQUEST FORM

Please provide all of the information requested below.	Date:

Billing Provider Information	
Facility/group practice name	
Organization NPI number	
Business location (city, state)	
Contact name	Contact phone number
Contact email address	
Contact mailing address	

Servicing Provider Information	
Servicing individual provider name	Individual NPI number

Effective Date Change Request Information
Date of requested effective date change for billing group/facility provider
Date of requested effective date change for servicing provider
Dollar amount in claims
Diagnosis codes on claims
Procedure codes on claims

Reason for effective date change request

- ☐ Emergency services
- ☐ Out-of-state services
- ☐ Retroactive client eligibility
- ☐ Letter attached
- ☐ Claim attached

All effective date change requests must meet the criteria listed in Washington Administrative Code (WAC) 182-502-0005 available at http://apps.leg.wa.gov/wac/default.aspx?cite=182.

Mail this form and any attachments to:

Chief Medical Officer, Washington State Health Care Authority, P.O. Box 45502, Olympia, WA 98504-5562